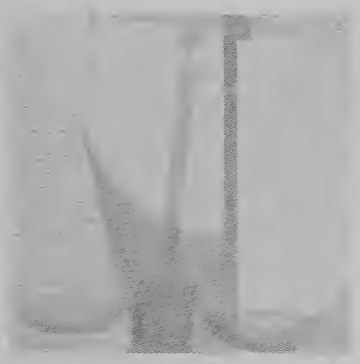
EVALUATION

Maximizing Your Prevention Efforts

prevention



maximizing your prevention efforts

By: Dr. Charlene Day

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dear colleagues:

Our 18 year history in HIV has yielded many lessons learned from the field. Funding for HIV programs have not increased proportionally with the level of need for communities of color. We have acknowledged that the HIV virus knows no color and that we need to create and maintain programs that "work." Programs that "work" need evidence of why they work. Now more than ever, we need to integrate Evaluation with our HIV Prevention programs. We need to evaluate why our programs work and the nuances of our cultures that are enablers or barriers to making our programs work.

The race for funding has become an endurance marathon, and this is the race we can lead because we understand and respect the nuances of our own cultures.

Since 1987, the National Minority AIDS Council (NMAC) has been committed to developing leadership within communities of color to address the challenges of HIV infection. Our work in technical assistance and training is a part of this commitment. As part of this work we acknowledge the need for evaluation as the precursor for planning your programs.

We would like to thank Charlene Day for the creation of this document, and deep appreciation to Virginia Bourassa for her involvement in the development process. Kudos also to Faith Hunter Kephart for oversight of the program activity and assurance that the goal was obtainable. A special thanks to The Gann Agency for their design insights and expertise and many thanks to the Centers for Disease Control for their funding support. ✓

This document is dedicated to the staff and volunteers on the front lines and in the communities who are on the pulse of the epidemic.

Yours in the struggle,

Paul Kawata

Executive Director,

Jackyie Coleman

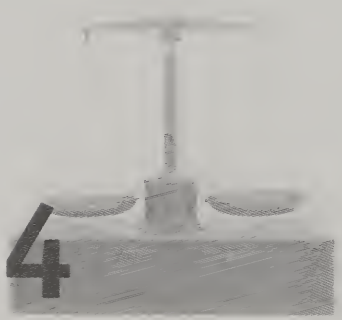
Technical Assistance

introduction

Throughout the past five years, NMAC has been a recipient of a grant from the Centers For Disease Control and Prevention National/Regional Minority Organizations Cooperative Agreement Program to provide technical assistance (TA) and training to community-based organizations that serve racial, ethnic and undeserved minority populations at risk for HIV and other STDs. Early in our project, we wanted to know if our TA efforts were useful, and whether or not our provision of advice and expertise made a difference to the many grantees to whom we provided services. Equally important, we wanted to "practice what we preach"... mainly that you must commit time, money and effort to evaluation at the very beginning of a project. In order to answer these questions, we employed an external evaluator.

Using an evaluator has been an important step in the development of the TA Division. We have been able to capture data and to list success stories, one after the other, because of our evaluation plan. As a result of our evaluation efforts we can tell you the number and type of TA delivered over the course of our grant period and the perceived usefulness of that assistance. By the years end, we will be able to tell you whether the provision of TA made a difference in the problem area cited by the agency. For example, if the agency sought TA in board development, our evaluation will help us to know if a board of directors has been established within one year after the provision of our TA.

Evaluation can also be an instructive tool which can help Managers adjust or enhance its program throughout the intervention. For example, through evaluation, NMACs TA division was able to demonstrate the regional impact of their technical assistance program across the United States. In the third year of the provision of grants, NMAC provided technical assistance to 30 agencies. Technical assistance was provided to two organizations in Hawaii, three in the midwestern states eight in the northeastern states, ten in the southern states, five in the western states and two in Puerto Rico. These agencies represented six regions throughout the United States, including the U.S. territory, Puerto Rico. Having this information was useful to the NMAC staff as they further developed strategy to expand their technical assistance to populations in need. NMAC used this information to enhance advertising, and expand the range of request for proposals disseminated. These efforts resulted in an expanded service population by the fifth year of its grant.



At the conclusion of its five year cooperative agreement with the federal Centers For Disease Control and Prevention, (1998), NMAC has provided technical assistance grants to over 120 HIV/AIDS prevention organizations in over 31 states. NMACs evaluation has also enabled the staff to see changes in the needs of technical assistance grantees over the five year period. In the third year of NMAC's technical assistance grants, a great demand was made for assistance in the area of board development. However, in the 04 year of the provision of grants for technical assistance, NMAC witnessed a shift in priorities stated by grantees to resource development. This area remains the most frequently requested area for assistance in the 05 year of technical assistance grants.

I hope that through this demonstration of the impact of evaluation, that you may begin to see its necessity and usefulness to the program planner. Armed with only this rudimentary form of evaluation, NMAC could be poised to request additional funds from its grantor because it can prove there is a need for technical assistance in specific areas. NMAC staff could also tailor their technical assistance programs by employing consultants in the area in which needs are being expressed, and continue to respond in a highly organized, user friendly manner to technical assistance grantees.

Evaluation findings may not always be positive, or statistically significant, but the data is almost always useful. We urge you to read this manual and to refer to it frequently as you contemplate the evaluation needs of your HIV/AIDS prevention program. The manual is divided into the three sections described below:

Stages and Phases Of Evaluation

This article, written by our Project Evaluator, Dr. Day provides an overview of the stages and phases of evaluation that many HIV/AIDS prevention organizations encounter. While examples are given about the size, type of agency, services rendered and length of time in the HIV/AIDS prevention arena, this information should only be viewed as a guide. Your organization may or may not have some of these qualities. In order for this section to be instructive and useful, the reader should not become mired in the organizational classification, but rather focus on the evaluation dynamics for each phase, and the action plan for evaluation improvement.

continued on next page

Evaluation Instruments

This compilation of actual evaluation instruments used by HIV/AIDS prevention organizations provides the reader with a potpourri of tools that can be used in evaluating HIV/AIDS programs. These instruments are provided so that organizations may review and adapt data collection tools that are being used by other prevention programs.

Glossary of Terms

A glossary of terms is provided to assist the reader in understanding the plethora of terms used throughout this document.

NMAC Survey

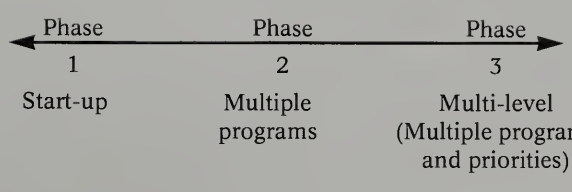
Mentioned previously in this introduction, NMAC's TA staff seeks to practice what we preach. Thus we have included a brief survey seeking your input on the usefulness of this manual and your perceptions about evaluation efforts in your agency. Please take a few minutes to assist us in our evaluation efforts by completing this survey and mailing it to us today. All that is required is your anonymous response and placement of the completed survey in your local mailbox.

Note: NMAC's evaluation includes both process and outcome measures. If you are interested in other measures used by NMAC's Technical Assistance Division, please feel free to contact Dr. Day at (202) 291-8975.

the three phases of evaluation

Throughout the past decade, government agencies, along with national and community-based organizations have worked diligently to prevent increases in the number of people infected with HIV/AIDS. As resources — financial and human —become increasingly competitive, the HIV/AIDS prevention community has become acutely aware of the need to demonstrate the value of its prevention efforts. By engaging in rigorous evaluation of prevention efforts, organizations can assess whether change in attitudes, beliefs and behaviors has occurred, and whether that change can be attributed to a specific prevention effort. The description of the various phases of evaluation in HIV/AIDS prevention efforts are described below, along with suggested action steps organizations can take to enhance evaluation strategies.

PHASES OF HIV/AIDS PROGRAM EVALUATION



Phase 1, Phase 2 and Phase 3 are points at which agencies and organizations can assess their progress towards developing and implementing evaluation plans for HIV/AIDS prevention programs. The phases described are fluid and dynamic; therefore organizations may find elements of themselves in one or more of these three phases. The evaluation descriptions provided seek to capture the essence of an HIV/AIDS prevention effort at a specific time. While reviewing each of the three phases, HIV/AIDS Program Managers and staff may see aspects of their organization in one or more phase. Try to focus on the phase that most accurately represents where your organization is in its development of an evaluation strategy.

PLEASE NOTE: While reviewing each of the three phases, HIV/AIDS Program Managers and staff may recognize similarities in some or all aspects of a particular phase. Do not limit/restrict yourself to one phase simply because the initial demographic do not fit your organization's current status.

phase one evaluation in HIV/AIDS prevention programs

Description

Organizations in the "Phase One" stage of evaluation tend to be described by their passion and commitment to HIV/AIDS prevention. In many cases, an organization in the "Phase One" stage of evaluation may be a new or start-up community based organization (CBO). They may also be organizations that evolved from a "grassroots" experience and have become so involved in the provision of services that lack the staff or resources to shift focus to evaluation. This type of CBO may have been created for the sole purpose of decreasing the rate of newly infected persons with HIV in the community. Very often, the funding they have received is stipulated for use in outreach and education efforts only. A majority of the staff may be volunteers. In many cases, CBOs have received funding because they've made a persuasive argument that their particular services are worthwhile and will produce a desired outcome. However, "proving" this relationship between the program and outcome is generally a theoretical argument.

Generally staff organizations in the "Phase One" stage of evaluation have as their primary focus the dissemination of information, education materials, and the distribution of condoms. Organizations in the "Phase One" stage may also be conducting HIV/AIDS 101 and 201 workshops throughout the community, making referrals to service related agencies and working collaboratively with organizations within their communities.

Limitations

Because groups of people, organizations or agencies in "Phase One" evaluation may be new or in a start-up category, staff is usually more concerned with conducting outreach efforts, which may include dissemination of flyers, condoms and other information in the field. Organizations in the "Phase One" stage of evaluation organizations may or may not have a requirement in grant and funding resources to conduct evaluation. The expense — financially and otherwise — may appear to be unwarranted. It is not unusual for organizations in "Phase One" evaluation to indicate we simply want to do the job that we are receiving money to do. Weighting us down with counting the number of condoms and brochures we disseminate takes away staff from the valuable role they play out in the field. More often than not, however, organizations in the "Phase One" stage of evaluation may contract with an evaluator to develop the grant proposal, or the evaluation component of the grant proposal only. This often the only point of contact the organization has with an evaluator.

Enhancing your evaluation strategy

In order to continue to work and receive funds in the highly competitive HIV/AIDS prevention arena, CBO's are increasingly being called upon to document or evaluate prevention efforts. This mandate requires that even the most rudimentary CBO begin to systematically collect data to prove its existence, validate that prevention efforts have occurred, and begin to demonstrate whether or not the prevention efforts have made an impact on the target population serviced. The information provided below can assist HIV/AIDS prevention organizations in "Phase One" stage of evaluation to enhance their evaluation efforts.

evaluation action steps (process)

Meet with all staff, including volunteers, to discuss the value of evaluation (See NMAC TA Newsletter July 1996). Engage in an exercise that requires each staff person to brainstorm and describe what they believe to be the major goal, objectives and activities of your HIV/AIDS prevention program. This process is sometimes referred to as defining GOAM, an acronym for Goals, Objectives, Activities, and Milestones.

GOALS	A statement that indicates what a program is supposed to produce. A goal statement describes the intended consequences (sometimes referred to as outcomes) of the program being developed.
OBJECTIVES	Tasks that must be completed to achieve the goal.
ACTIVITY	The specific tasks/function undertaken to accomplish the objective
MILESTONES	A significant point in the development towards the goal.

Develop an evaluation plan. Together with staff, develop a plan which outlines the aforementioned planning and evaluation strategy (GOAM) using the 5 W's to describe the full program.

WHO	Who benefits from the prevention services? Describe the population in terms of demographics, need, and response levels; compare them to pre-existing prevention efforts.
WHAT	What specifically is your prevention program doing? Are you trying to increase knowledge regarding behaviors that put individuals at risk for HIV/AIDS? Are you trying to provide condoms and hopefully teaching how to use condoms properly to a select population? Outline specifically what it is you are doing and the rationale for each using this approach over another.
WHEN	Describe when you conduct activities related to your objective and under what conditions.

WHERE

Describe the places in which your HIV/AIDS prevention activities might occur. For example: Do you conduct HIV/AIDS 101 workshops in beauty and barber shops between the timeframes of 5-9 on Friday evenings.

WHY

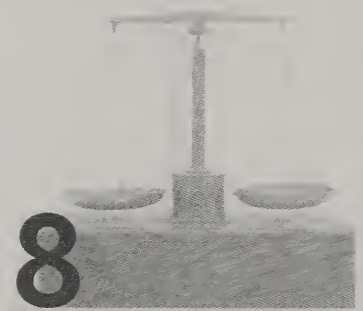
This question sets the evaluation in motion. What are the particular questions the funders want you to answer about the population in need? If you are only interested in whether or not knowledge was changed as a direct result of your AIDS 101, then a pre/post workshop survey might suffice. However, if you are interested in knowing whether or not the individual plans to change behavior as a result of your workshop, a different type of survey and intervention methodology might be employed. Additionally, organizations must question the theory or approach selected. Why did the organization select one approach over another? Is there any "proof" in the professional literature (journals/articles) which supports your use of this approach.

Conduct *brief surveys before and after the prevention workshop (pre/post tests). DO NOT REINVENT THE WHEEL. Federal, state and local health departments, the National Prevention Information Network (NPIN), and fellow CBO's may have already developed and validated a pre/post test to be used in basic HIV/AIDS workshops. Test the appropriateness of the instrument for your selection population by administering the test and asking for feedback regarding ease of administration, and level of understanding. This approach to survey validation is called a pilot.*

Collect *and tally demographic information from individuals who receive brochures information packets and condoms.*

Develop *quarterly reports for funders, board members and staff detailing the organization's progress towards reaching stated goals and objectives. Within the reports, provide:* ***1.*** *a description of the approaches used to reach each objective,* ***2.*** *an outline of the major prevention activities undertaken within the quarter,* ***3.*** *a listing of challenges and/or limitations throughout the quarter, and;* ***4.*** *a discussion of strategies to redress the limitations.*

Record *minutes of meetings with staff, board members and community members.*



phase two evaluation in HIV/AIDS prevention programs

Description

Organizations in the "Phase Two" stage of evaluation are best described by their older sibling status. They are no longer the new kids on the block and may have more than one issue area for which they receive significant external funding. Organizations and agencies in Phase Two stage evaluation may be conducting outreach, referral and treatment services in addition to their prevention services. Staff includes full time, professionally-trained health educators, salaried and hourly wage workers, and volunteers. The passion for HIV/AIDS prevention exists, but is tempered with the realities of participation in the HIV/AIDS arena for many years. This reality bespeaks problems that are constant. There is the challenge of retaining staff who often lose energy and enthusiasm working in an arena which is stress ridden, labor intensive, and emotionally draining. Additionally, there is the fluctuations in funding cycles which sometimes reflect the greater priority to fund one risk category or selected population over another.

Oftentimes, organizations in "Phase Two" have been conducting process and outcome based evaluation over the course of a three to five year grant. These organizations or agencies may use epidemiological data collected by their staff or at the local and state health department level to justify the need for prevention services they render. They may use state developed instruments including self report behavioral measurement surveys, pre/post workshop surveys and focus groups to ascertain changes in the population for whom prevention services are targeted. Organizations in Phase Two may have allocated money within grants and through general staff budgets to hire an internal evaluator.

Limitations

Organizations and agencies in "Phase Two" evaluation may become victims of the "I know what works" mindset. Because they have worked with a select population for a few years, they may develop a dominant attitude, and this can impact program evaluation. The organization may also begin to perceive that since they have worked with a particular population for a period of time, then their knowledge and opinions give them the inherent right to create prevention programs. If this rigid type of thinking continues, it might result in a stagnancy of prevention programs in an evolving disease.

Enhancing your evaluation strategy

The aforementioned thinking can prove problematic to evaluation planning and implementation if it does not prompt Program Managers to consider some of the following questions:

How do you know your intervention strategy and related activities are the most effective one for the population in need?

Have you used health education or health behavior theory to develop to undergird your evaluation plan?

continued on next page

Have you taken steps to insure that the instruments you are using are culturally appropriate and sensitive to gauge the knowledge, beliefs and behaviors of the population in need?

Have the instruments you elected to use from the state and/or other CBOs been tested and proven to be sound on your selected population in need?

Have you considered that using an internal evaluator only may lead to potential bias?

Have you utilized a variety of evaluation strategies, quantitative and qualitative, to gather information and validate findings?

How do your posters, flyers, and other outreach efforts are being perceived and received by the population in need?

Have you conducted follow-up evaluation regarding receptivity of your instruments?

Have you assessed whether or not your organization is engaging in both impact and outcome based evaluation?

How reflective is your staff (from the Executive Director to the volunteers) of the population in need, and does this make a difference in the receptiveness and honesty in reporting of information from your selected population?

Evaluation Action Steps

1 Consider whether or not your organization/agency can attribute a change in knowledge, beliefs or behavior to your specific intervention. How do you know it was your program, and not something external which made the difference? The discipline of health education provides excellent training on how to develop, implement and evaluate health enhancement and disease prevention initiatives.

2 As organizations and agencies move deeper into HIV prevention, they are finding that more proof is required to demonstrate that the strategy was appropriate for the population in need. Increasingly, funders are seeking to know the theory's that the organization used to develop programs. If, however, the agency has developed a new theory, it is expected that theory will be grounded in sound research and tested for both reliability and validity. Once again, the discipline has developed and validated theories on health behavior change as well as borrowed from other health related disciplines to compile a broad list of theories which may explain under what circumstances an individual may change his/her behavior. Review existing theories on health behavior and consider validating it on the organization's population in need. If the theory does not work, contrary to popular opinion, this does not constitute a negative finding. In fact, finding out that a theory may not work on a specific population in need is valuable to the research field.

3 While many CBOs have developed instruments to assess needs and strengths

always be appropriate for your population in need. who is to say an instrument that works well and gathers accurate data for one population will do the same for another. For example, an instrument that gathers sexual behavior among gay black men in San Francisco, California may not be effective on gay black men in Birmingham, Alabama. Sometimes, minor changes in terminology, phraseology and syntax may be required to make it appropriate for your selected population. Always pilot an instrument with a subset of your population in need before implementing the survey on a large scale.

4 Using varied evaluation techniques helps to insure that you have truly understood the measure your population in need is trying to convey about your intervention. For example if you combine qualitative research, say a focus group for example, before developing a needs/strength assessment, you will have a good sense of what the community will respond to on a written survey. Indeed, you may also gain knowledge about whether or not they will inclined to respond to a written survey. Once the survey has been administered, and the quantitative data analysis conducted, it would be useful to follow-up the survey with another qualitative approach of key informant interviews which could be used to probe deeper into why a specific response may have been given to a specific question.

5 Consider hiring someone on staff to evaluate the effectiveness of your program. Allocate a portion of your grant to instrument research, development, and validation.

phase three evaluation in HIV/AIDS prevention programs

Description

Organizations and agencies in the "Phase Three" stage of evaluation may house HIV/AIDS prevention and treatment programs as well as initiatives on Alcohol and Substance Abuse, Violence and Housing for the Homeless. These organizations may focus on multiple health and social service related concerns and may have up to 25 projects being conducted simultaneously, targeting the same community in need, and receiving various funding from numerous foundations, federal and state agencies and local organizations.

Organizations in the "Phase Three" stage of evaluation are frequently large organization with multiple programs and multiple priorities. These organizations have also been doing HIV/AIDS prevention for some time. Organizations in this phase may have a different set of descriptors than others referenced above. They may be: a) national and regional organizations receiving funding by the Centers for Disease Control and Prevention (CDC) or other funders, b) community –based organizations who have been involved in HIV/AIDS prevention, service provision and treatment for years, and/or c)not-for-profit and for-profit organization who have partnered with community entities to incorporate HIV/AIDS into a larger prevention effort.

Limitations

Organizations and agencies in the "Phase Three" stage evaluation are sometimes plagued by funding constraints, conflicting priorities, and inconsistent messages from the community in need, and an administrative agenda which may not fully embrace the need for rigorous evaluation. This attitude among administrators may exist even when funders have indicated that organizations must allocate a specified amount to evaluation of individual prevention programs.

Enhancing your evaluation strategy

Program planners may have to consider some of the following questions when attempting to enhance existing evaluation strategy.

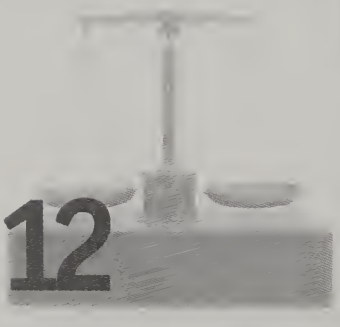
Organizations in "Phase Three" evaluation must collect outcome data. What were the results of your intervention? Did you change attitudes or behavior with your specific intervention?

Organizations in "Phase Three" frequently participate in cooperative agreements with funding entities which require them to work in concert and cooperation with the funder. Are there significant differences between the desired outcomes of the funder and of the community in need?

Organizations in "Phase Three" may be further removed from the immediate population in need and therefore may face unique challenges in data collection. Is your proximity, physically and philosophically, consistent with the community in need?

Evaluation Action Steps: 4A's

Allocate funds: Consider allocating funds, (10-15% of the grant) for an external evaluator. Try to make certain that



you select someone who has had specific background and experience in HIV/AIDS program evaluation, or at the very least is a Certified Health Education Specialist with an emphasis in evaluation.

Acknowledge bias: While using an internal evaluator is an important step in the right direction towards evaluation of your HIV/AIDS prevention program, there exists a certain bias that is inherent in internal evaluation. Very often internal evaluators have more than one program to which they are assigned. Staff are frequently competing for the attention of the evaluator, and sometimes set guidelines which are difficult with which to comply. Equally important is the fact that the internal evaluator is a part of the staff and therefore wants the program/project to succeed. This bias might be reflected in the reporting and interpretation of findings. For example, an internal evaluator conducting a focus group which is seeking to ascertain perceptions of the community about your AIDS 101 classes may find himself/herself in a compromising position. He or she wants to garner the information but may bias the group responses because of his/her position within the agency. The responses and findings of the focus group may result in limitations which impact the validity and reliability of the data.

Accent knowledge: Make known (in the funding application process) the unique aspects (cultural, regional, etc.), of your population in need. The uniqueness of your population in need and the need for unique approaches in prevention strategies may not be known to your funding agencies. For example, many HIV/AIDS organizations that develop programs for people of color recognize and embrace the fact that a lot of the members of these cultural groups are from oral cultures. This factor has implications for evaluation. If a person tends to respond to questions better when they are presented verbally, then he or she may not be likely to respond to a four - six page written survey. Perhaps this individual feels that he or she can respond more accurately and/or elaborate on response through a verbal exchange. Having knowledge of the unique cultural considerations of your population in need, and then conveying this information to Project Officers and the research community at large is a responsibility of organizations in the "Phase Three" stage of evaluation.

Accurately reflect: Understand that the further the distance from the population in need (either physically or philosophically) the greater the potential for evaluation concern. Organizations in "Phase Three" must always continue to make certain that they are accurately reflecting the experiences and concerns of their population in need. Additionally, organizations in "Phase Three" must continue to appreciate the evaluation limitations of their constituents and strive to assist them whenever possible. For example, the "Phase Three" organization may represent over 100 organizations in Phase One. There may be organizations which are using volunteers to disseminate condoms and brochures on the streets in select neighborhoods from 8pm - 2am daily. The time in which these CBO's can respond to request from the national organizations, and the restrictions of data collection at 1pm must be understood and appreciated by the national organization. The organization in "Phase Three" of evaluation then has the additional burden of impressing upon CBOs the need to complete data collection instruments and forward them to their offices accurately and in a timely fashion.

glossary of key terms

Accountability: Responsibility of program staff to provide evidence - to sponsors, boards and the community among others — of conformity to program specifications and fiscal requirements.

Activities: The day-to-day tasks involved in program planning and development that the member of the population in need participates in and/or are impacted by.

Community Analysis: one form of needs assessment that examines the characteristics and health problems of a community.

Control Group: A segment of the target group not receiving intervention.

Culture: The shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people.

Cultural Competence: A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports.

Cultural Diversity: Differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation. A city is said to be culturally diverse if its residents include members from different groups.

Culturally Appropriate: Demonstrating both sensitivity to cultural differences and similarities and effectiveness in using cultural symbols to communicate a message.

Ethnic: Belonging to a common group - often linked by race, nationality, and language - with a common cultural heritage and/or derivation.

Goals: A statement that indicates what a program is supposed to produce. A goal statement describes the intended consequences of the program being developed.

GOAM: An acronym for Goals, Objectives, Activities, and Milestones; a planning and evaluation strategy for assessing tasks necessary to complete a project.

Impact evaluation: Assess the immediate effects of a program.

Experimental Group: Segment of the target population to whom an intervention is delivered and whose impact/outcome measures are compared with the control group.

Intervention: An planned activity designed to produce intended changes in a target population.

Mainstream: A term that is often used to describe the "general market," usually refers to a broad population that is primarily White and middle class.

Milestones: A plan to evaluate. Built in steps in your prevention program which encourage you to evaluate the success of your activities toward the overall objective.

Multicultural: Designed for or pertaining to two or more distinctive cultures.

Nationality: The country where a person lives and/or one that he or she defines as a homeland.

Objectives: Tasks that must be completed to achieve the goal.

Outcome Evaluations: Designed to examine the long-term effects of the programs in terms of morbidity and mortality rates

Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.

Reliability: Refers to the need to establish the internal consistency of the instrument; the ability to yield similar results/responses from the same respondent (in an unchanging situation) each time the instrument is used. A good example is a knowledge, attitude and beliefs survey instrument which is tested and time again on the same kind of respondent (freshman students at a local community college) and garners the same results.

Reliable Measures: A measure on which scores are reproducible in repeated administrations, assuming relevant factors are the same.

Validity: Refers to the degree to which the instrument actually measures what it purports to measure. Instruments must be BOTH reliable and valid. Reliability does not guarantee validity (i.e., and instrument can be reliable but invalid); however, an instrument which is not reliable can NOT be valid.

attachment #1 — 5W's worksheet

Use the 5 W's to describe your program. When developing an evaluation plan you may want to use the following form as a guide.

	Task	Your Program
WHO	1. To whom are you providing prevention services? 2. Describe the population in terms of demographic, need, and response levels to pre-existing prevention efforts.	
WHAT	1. What specifically is your prevention program doing? **a.** Are you trying to increase knowledge regarding behaviors that put individuals at risk for HIV/AIDS? **b.** Are you trying to provide condoms and hopefully teaching the proper use of condoms to a select population. 2. Outline specifically what it is you are doing and the rationale for each using this approach over another — i.e. are you distributing condoms in _____(reference) because ____ .	
WHEN	Describe when you conduct activities related to your objectives and under what conditions.	
WHERE	Describe the places in which your HIV/AIDS prevention activities occur. i.e. Do you conduct HIV/AIDS 101 workshops in beauty and barber shops between the time frames of 5pm- 9pm on Friday evenings.	
WHY	This question sets the evaluation in motion. What are the particular questions the funders want you to answer about the population in need.	

attachment #2 — GOAM worksheet

Evaluation Action Steps (Process)
The following is an example of how this project looks using the GOAM process for evaluation.

GOAM		Group/Action Steps
Goals	A statement that includes what a program is supposed to produce e.g. outcomes. A goal statement describes the intended consequences of the program being developed.	
Objectives	Tasks that must be completed to achieve the goal.	
Activity	The specific tasks/function undertaken to accomplish the objective.	
Milestones	A significant point in the development towards the goal.	

the agency

Note to the Reader: *Basic data gathering instrument (Phase I).*

DEMOGRAPHICS:

Gender: ☐ Male ☐ Female ☐ Transgender

Age: ☐ Under 12 ☐ 13-22 ☐ 23-31
☐ 32-40 ☐ 41-50 ☐ 51-60
☐ 61 and under

Ethnicity: ☐ African-American ☐ Asian/Pacific Islander
☐ Caucasian ☐ Latina/o
☐ Native American ☐ Other

Have you ever attended an AIDS 101 workshop before? ☐ yes ☐ no

What did you learn that you didn't know before?

Note to the Reader: *This an example of a culturally specific condom survey. You may use it to collect culturally specific data on your target population/risk group.*

1.Your Ethnicity

A. Asian

☐ Cambodian ☐ Malaysian ☐ Chinese
☐ Pakistani ☐ East Indian ☐ Thailander
☐ Filipino ☐ Vietnamese ☐ Indonesian
☐ Laotian ☐ Japanese ☐ Others _____

B. Asian Pacific Islander

☐ Guamaniam ☐ Samoan
☐ Hawaiian ☐ Others_____

2. Your Gender

☐ Male ☐ Female ☐ Transgender

3. Your Marital Status

☐ Single ☐ Married ☐ Divorced
☐ Other ☐ Partnered

4. Your Sexual Orientation

☐ Gay/Lesbian ☐ Straight ☐ Bisexual ☐ MSM

5. Are you sexually active?

☐ yes ☐ no

6. Do you know what condoms are used for?

☐ yes ☐ no

If no, why? ☐ Lack of information ☐ Cannot afford to buy
☐ Other reasons _____

7. Do you know how to use condoms properly?

☐ yes ☐ no

condom survey — cont'd

If no, why? ☐ Lack of information ☐ Language Barrier
☐ Other reasons _____

8. Do you use latex condoms?
☐ yes ☐ no

If no, what other condom do you use?
☐ Polyurethane ☐ Lambskin

9. Do you use another kind of condom?
☐ yes ☐ no

10. Do you use water base lubricants with the condoms?
☐ yes ☐ no

If no, what kind of lubricants do you use?
☐ K.Y ☐ Oil ☐ Vaseline ☐ Spit

11. Do you know where to get condoms and lubricants in your area?
☐ yes ☐ no

12. Do you want to get condoms and lubricants?
☐ yes ☐ no

I yes, give us your Zip Code. _____

13. Area/location where this survey was taken.
☐ Chinatown ☐ Uptown ☐ Rizal Center
☐ Edgewater/Rogers Park ☐ Other _____

If you want to receive condoms, lubricants and other information about safer sex, please contact The Agency at the number below:

Phone: 1-888-000-0000

Address: 1111 Street, Suite 222
City, State 22110

Note to Reader: *Questions for Focus Group/In-dept Interviews — This assessment can be reworded to ask clients about condoms, support groups, workshops, etc.*

Please fill out the questionnaire below to share your ideas on how to make the Exchange and the Harm Reduction Center more effective. Thank You

What types of syringes (size, etc.) and other supplies would you like provided at the Needle Exchange site?

What do you think are the best times, day or night, to conduct Needle Exchanges?

What are the most convenient and safest sites for Needle Exchange?

Would you use a site if it were indoors?

How do you think we can encourage more people to use the ex-changes?

What other services would you like provided at the site?

☐ Health Services
☐ HIV & Drug Counseling
☐ Vocational training
☐ Benefits counseling
☐ Voter registration
☐ Referrals to other agencies

the agency outreach log

Note to the Reader: *The tools can be used to validate collaboration and identification of the usage, distribution and tracking demographics.*

NAME: DATE: OUTREACH LOCATION:

 # OF CLIENT CONTACTS: _____

1. #IDU/DU ____ (donotincludeMSM/IDU here) **2.** # Sexual Partner (not IDU) _____

3. # Total MSM _____ (includes MSM and MSM/IDU, not IDU) **4.** Population Not Known _____

AGE:

Under 25 Over 25 Unknown

GENDER:

Female _____ Male _____ TG _____

ETHNICITY:

African American_____ Latino/Latina_____ White _____

Asian/Pacific _____ Native Amer. _____ Other/Unk _____

SEXUAL ORIENTATION:

Gay/Bisexual Males _____ Lesbian/Bisexual Females _____

Heterosexual Males _____ Heterosexual Females _____

SUPPLIES DISTRIBUTED:

Condoms _____ # Bleach Bottles_____ #Alcohol Wipes _____

Lubricants _____ # Dental Dams _____ # Offer_____

TOTAL # OF REFERRALS _____

Services Referred To:

HEALTH SERVICES

HIV Testing _____

TB Screening _____

STD Screening _____

Detox or Treatment_____

Medical Care Clinic_____

SOCIAL SERVICES

Needle Exchange _____

Foo&Food Banks_____

Shelter/housing _____

GA/S S I/A FDC_____

HIVIAIDS Support _____

Other Medical or Social Services *(Specify)* _____

Daily Activities Log

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date:_____ Session: _____ Attendance: _____
Notes:_____

Date:_____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

Date: _____ Session: _____ Attendance: _____
Notes:_____

pre-post test

Name *(optional)*: **Date:**

1. HIV is transmitted from human to human by:

a. sexual contact
b. blood-to-blood contact
c. insect bites
d. both A and B above

2. Which of the following body fluids does not transmit HIV?

a. blood
b. semen
c. saliva
d. vaginal secretions

3. The single best means of prevention from becoming infected with HIV is:

a. to only have sex with someone you know
b. wash your hands before and after any sexual contact
c. abstaining from any sexual contact or drug use
d. to use a condom always

4. AIDS stands for: (Check the correct answers.)

a. acquired intravenous deficiency syndrome
b. acquired immune deficiency syndrome

HIV stands for:

a. Human Immunodeficiency Vaccine
b. Human Immunodeficiency Virus

5. What is the main role of the white blood cells?

a. to send pain messages to the brain
b. to decide the sex of an unborn child
c. to make more growth hormones
d. to fight off infection in the body

6. What is the main role of the T-helper cells?

a. to make more protein in the muscles
b. to make adrenaline
c. to organize the body as immune defenses
d. to shut off the body's pain signals

pre-post test — cont'd

7. What happens to the white blood cells after HIV infection?

a. they turn into red blood cells
b. they are destroyed by the virus
c. they become cancer cells
d. they grow out of control

8. Why is HIV different from other viruses?

a. it uses the immune system's cells to grow
b. both animals and humans can get it
c. it dies at once from touching white blood cells
d. it can be killed by T-helper cells only

9. What is an opportunistic infection?

a. infection that waits until the body reaches a certain age
b. infection that can be cured by aspirin and rest in bed
c. infection that lives on red blood cells
d. infection that takes advantage of damaged immune system

10. How is HIV passed on to another person during sexual intercourse?

a. through sweat from body contact
b. through saliva when kissing
c. through semen, vaginal fluids, and menstrual blood
d. through semen, vaginal fluids, and body sweat

11. Which sexual practices can transmit HIV?

a. anal sex only
b. vaginal, anal, and oral sex
c. anal and oral sex only
d. vaginal sex only

12. How is HIV spread through needle use?

a. illegal IV drugs carry the virus
b. the virus can cling to the outside of a needle before it is used
c. infected blood in used needles can by injected into the next user
d. soaking used needles in bleach will kill everything but the AIDS virus

13. What are the two ways HIV test results are handled in labs?

a. public, open
b. anonymous, confidential

c. secret, goes into a state data bank
d. shown to the doctor, then destroyed

14. What is the most widely known drug in treating AIDS?
a. amoxicillin
b. AZT
c. ARC
d. ventolin

15. List three things persons with AIDS can do to take care of their overall health?
a.
b.
c.

16. What is the surest way to keep from getting infected with HIV?
a. use a condom during sex
b. never shoot IV drugs
c. abstain from all high risk behaviors
d. avoid the use of public toilets

17. Why should condoms be used during sexual intercourse?
a. you can pass on a disease by having unprotected sex
b. condoms are an important disease prevention method
c. everyone must take responsibility for stopping AIDS
d. all of the above

18. Which type of condom is best for protection against HIV?
a. lambskin
b. tissue
c. latex
d. seal skin

19. The best way to keep from getting infected with HIV from needles is to stop using them completely. But if a person keeps on using needles, what is the next best thing to do?
a. don't share needles with strangers
b. wash hands after every use
c. share needles only with people you know
d. always clean needles in bleach before using

pre-post test — cont'd

20. What does the term "universal precautions" mean?

a. standard disease protection practices
b. a brand of condoms
c. standard ways to decide who has AIDS
d. a type of plastic glove

21. The First HIV antibody test became available in what year?

a. 1980
b. 1985
c. 1987
d. 1991

22. In general when a person wants to be tested for HIV Antibodies what must be obtained from the by the agency doing the testing?

a. ten dollars
b. informed Consent
c. demographic information
d. proof of age

23. If someone was exposed to the HIV/AIDS virus, what is the maximum amount of time it could take for the virus to show up in their blood, if were tested.

a. 6 months
b. 2 years
c. 5 years
d. l0 years

24. An infected woman can transmit HIV to unborn to newborn baby:

a. through breast feeding
b. during the birth process
c. during pregnancy
d. all of the above

25. The HIV virus can be transmitted from needle use by:

a. tattooing and body piercing
b. donating blood
c. steroid use
d. Both A and C

session evaluation form

NAME *(OPTIONAL)*: DATE:
OUTREACH LOCATION:

Your comments are important and useful to our program. Please take a few minutes to fill out this evaluation. We will take your comments into consideration for future sessions. Thank You.

1. How much did you know about HIV or STD's before this session?
☐ A lot ☐ Some ☐ Very Little ☐ Nothing

2. How much did this session help you to understand HIV?
☐ A lot ☐ Some ☐ Very Little ☐ Nothing

3. Are you now able to identify the ways HIV and STD' are passed on to another person?
☐ Yes ☐ No ☐ Unsure

4. Are you now able to identify "high-risk" behaviors for HIV and STD's?
☐ Yes ☐ No ☐ Unsure

5. Do you feel that you will change some of your "high-risk" behaviors as a result of the information you have received?
☐ Yes ☐ No ☐ Unsure

6. Do you feel that the instructors had good knowledge of the subject?
☐ Yes ☐ No ☐ Unsure

7. Do you feel ALL topics were thoroughly covered?
☐ Yes ☐ No ☐ Unsure

8. Was the material presented valuable to you?
☐ Yes ☐ No ☐ Unsure

9. Did you feel comfortable asking questions or making comments?
☐ Yes ☐ No ☐ Unsure

continued on next page

session evaluation form

10. Have you been tested for HIV?

☐ Yes ☐ No

If no, would be more willing to be tested, now that you have attended HIV classes?

☐ Yes ☐ No ☐ Unsure **Why?**_____

session evaluation *(continue for Juveniles only)*

Are there any other HIV topics that you would like to learn about in a future program? If you were to test positive for HIV tomorrow, what would you do? How do you think your friends and family would react if you told them you were HIV positive? How would you react to learning that a friend or family member was HIV positive?

1.When you engage in sexual activity, how often do you use a condom?

☐ Always ☐ Most times ☐ Sometimes ☐ Never

Why or Why Not?

3. After your release, would you be interested in helping us make a video about HIV and AIDS?

Yes or No, Why?

4.What part of the HIV/AIDS classes did you enjoy the most?

revised 10/97 EVAL. CDC/Juv only

presentation evaluation

Please fill out the following evaluation and pass in at the end of the presentation.

Title _____

Date: _____

Site: _____

Presenter(s): _____

PROFILE OF AUDIENCE:

Please put a check next to the category which describes yourself:

☐ M ☐ F

☐ African-American ☐ Latino ☐ Native American

☐ Euro-American ☐ Cape Verdean ☐ Brazilian

☐ Haitian ☐ Asian ☐ Other (Specify_____

1. How would you rate the overall presentation?

☐ poor ☐ average ☐ good ☐ very good ☐ excellent

2. Was the material presented...

☐ inappropriate ☐ appropriate

3. How would you rate your opportunity to participate?

☐ poor ☐ average ☐ good ☐ very good ☐ excellent

4. What was most helpful about the presentation?

5. Do you have any suggestions or recommendations about the presentation?

6. Are there specific topics you would like to see addressed in future seminars?

individual staff evaluations

Please mark the appropriate rating for the following presenter(s), using "P" for poor, "AVER" for average, "G" for good, "VG" for very good, and "EX" for excellent:

John Doe 1	☐ P	☐ AVER	☐ G	☐ VG	☐ EX
Jane Doe 1	☐ P	☐ AVER	☐ G	☐ VG	☐ EX
Jane Doe 2	☐ P	☐ AVER	☐ G	☐ VG	☐ EX
John Doe 2	☐ P	☐ AVER	☐ G	☐ VG	☐ EX
John Doe 2	☐ P	☐ AVER	☐ G	☐ VG	☐ EX
Jane Doe 3	☐ P	☐ AVER	☐ G	☐ VG	☐ EX
John Doe 3	☐ P	☐ AVER	☐ G	☐ VG	☐ EX

monthly/quarterly report

RACE/ETHNICITY:	☐ Nat. Am./Ala. Nat.	☐ Asian/ Pacific Is.	☐ Black (non-H/H)
	☐ Haitian (any race)	☐ Hispanic (any)	☐ White
	☐ Other/Unknown		

MEN								
0-14	___	___	___	___	___	___	___	___
15-19	___	___	___	___	___	___	___	___
20-29	___	___	___	___	___	___	___	___
30-39	___	___	___	___	___	___	___	___
40-44	___	___	___	___	___	___	___	___
45+	___	___	___	___	___	___	___	___
Undetermined	___	___	___	___	___	___	___	___
MEN SUBTOTAL	___	___	___	___	___	___	___	___ *(total men)*
WOMAN								
0-14	___	___	___	___	___	___	___	___
15-19	___	___	___	___	___	___	___	___
20-29	___	___	___	___	___	___	___	___
30-39	___	___	___	___	___	___	___	___
40-44	___	___	___	___	___	___	___	___
45+	___	___	___	___	___	___	___	___
Undetermined	___	___	___	___	___	___	___	___
WOMAN SUBTOTAL	___	___	___	___	___	___	___	___ *(total men)*
TOTAL CONTRACTS	___	___	___	___	___	___	___	___ *(grand total)*

BEHAVIOR RISK EXPOSURES	#	%
High Risk Behavior		
IDUs:	___	___
MSM:	___	___
MSM and IDUs:	___	___
Hetero. Sex Partners of MSM:	___	___
Sex Partners of IDUs:	___	___
Sex Partners of HIV+s, PWAs:	___	___
Total High Risk	___	___
Increased Risk Behavior		
Non-monogamous Heterosexuals:	___	___
Substance Abusers:	___	___
Total Increased Risk	___	___
Undetermined/No Identified Risk:	___	___
Total Contacts in Risk Groups	___	___
Total # of condoms distributed:	___	___
Total # of brochures distributed:	___	___
Total # of Referrals to:	___	___
STD Clinics:	___	___
HIV C/T:	___	___
TB Clinics:	___	___
Prevention Case Management:	___	___
Total Referrals:	___	___

TARGET GROUPS	#	%
Persons who barter sex:	___	___
Persons infected with STDs:	___	___
At-Risk Youth:	___	___
Persons Infected with TB:	___	___
Homeless Persons:	___	___
Migrant/Seasonal Farmworkers:	___	___
Inmates/Paroles:	___	___
General Population/Others:	___	___

EDUCATION & OUTREACH CONTACTS		
Total number education sessions:	___	___
Total contacts from education:	___	___
Pre- and Post-tests conducted in:	___	___ *ed sessions*
Participant evals. conducted in:	___	___ *ed sessions*
Total number of outreach hours:	___	___
Total contacts from outreach:	___	___
Total number 1-on-1 contacts:	___	___
Materials/Referrals/Assessments:	___	___

MATERIALS/REFERRALS/ASSIGNMENTS		
Behavior Assessment		
1. # reporting intended change:	___	___
2. # reporting actual change:	___	___
Total # of Pre/Post-tests conducted:	___	___
1. Average Pre-Test score:	___	___
2. Average Post-Test score:	___	___
3. Average Change (+/-):	___	___

Signature of Project Officer _____

Date _____

evaluation document survey

Please complete and return this survey to NMAC's Technical Assistance Division. This will assist us in responding to your Technical Assistance needs in the area of Program Evaluation. MAIL THIS SURVEY TO: **Technical Assistance Division National Minority Aids Council, 1931 13th Street, NW, Washington, DC 20009-4432.**

Agency Name: *(optional)*_____

Address (*city/state/zip code)* _____

_____

Telephone # *(optional)*_____

Do you consider your organization *(mark those that apply)*

☐ National ☐ Regional ☐ Community Based ☐ Church Affiliated
☐ Government ☐ Not for profit ☐ Private ☐ other _____

Does your agency have HIV Prevention programs? ☐ Yes ☐ No

Number of staff working in HIV Prevention _____.

Which populations do you serve? *(please mark all that apply)*

☐ African American ☐ Latino ☐ Asian & Pacific Islander
☐ Native American ☐ Caucasian ☐ MSM
☐ Women ☐ IDU ☐ Youth
☐ Incarcerated ☐ other _____

Did you read the entire document? ☐ Yes ☐ No

Was the material useful? ☐ not useful ☐ somewhat useful ☐ useful ☐ very useful

According to this material, please rate the phase you think your agency is in

☐ Phase 1 ☐ Phase 2 ☐ Phase 3

Are you currently evaluating your programs? ☐ Yes ☐ No

Do you have an outside evaluator? ☐ Yes ☐ No

What type of evaluation do you use? ☐ Process ☐ Outcome ☐ Impact ☐ None

If you were to receive technical assistance in Evaluation please check off what you are currently doing (Current) *and rank your priorities in the right column* (1 being the most important).

CURRENT	EVALUATION	FUTURE
	Theories of Evaluation	
	Developing evaluation Instruments	
	Methods in Evaluation Design	
	Innovative Data Collection Strategies	
	Culturally Sensitive Evaluation Techniques	
	Writing Evaluation Plans	
	other:	

Please copy and MAIL IN

NATIONAL
MINORITY
AIDS
COUNCIL

1931 13th Street, NW Washington, DC 20009 P (202)483.6622 F (202)483.1135